Department of HUMAN SERVICES

KELLY GARCIA, DIRECTOR

DATA STEERING COMMITTEE MEETING MINUTES
DECEMBER 19TH, 2019 – 11:00 A.M. – 1:00 P.M.

DATA STEERING COMMITTEE MEMBERS

Gerd Clabaugh	*Department of Public Health*	Nick Gerhart	*FBL Financial Group, Inc*
Mikki Stier	*Department of Human Services*	Laura Jackson	*Wellmark*
Steve Stewart	*IHIN*	Tom Newton	*Wellmark*
Kelly Garcia	*Department of Human Services*	Mike Randol	*Iowa Medicaid Enterprise*
Mary Cownie	*Mercy Health Network*	Sabra Rosener	*Unity Point – Government Relations*
Derek Novak	*Mercy Health Network*	Laura Smith	*Unity Point*
Lee Carmen	*University of Iowa Health Care*	Dr. Christina Taylor	*The Iowa Clinic*
Jennifer Vermeer	*University of Iowa Health Care*	Beth McGinnis	*Iowa Clinic*
Liz Matney	*iGOV*	Henry Marquart	*Genesis Regional*
Doug Ommen	*IID*	Megan Maher	*IHIN*
Meghan O'Brien	*iGOV*	Arron Todd	*IPCA*

WELCOME AND OPENING REMARKS

At the last Data Steering Committee meeting, the committee went through the prioritized Use Cases that were discussed at length at the Roundtable meetings over the summer. We had a number of different additions to the Data Steering Committee and some people who were not involved in everything that led up to the summarization and prioritization of those Use Cases. Because of this, the committee wanted to revisit, level set and validate those conversations and assumptions that went into summarizing those Use Cases.

During this meeting, the committee walked through and validated assumptions and received feedback on whether these assumptions hold true for the updated group.

AGENDA TOPIC: DISCUSSION AND DEVELOPMENT OF OUR USE CASES

Review of Use Cases

- Longitudinal patient record
- Summary of Care Information
- Results reporting and document delivery to ambulatory providers.
- Public Health data reporting
- Real-time event notification.
- Connecting C3 Organizations
- Data aggregation for population- health and utilization-management analytics
- Dashboards
- Electronic PreAuthorization
- Cost Price Transparency Data Needs and Tools to support
- Decision Support Tools
- Identifying High Costs/ High Need Populations

For Use Case summary, clinical value, business value and data required please refer to the Use Case attachment.

After the review of the Use Case document, discussion continued regarding implementation and process of how we are going to complete the next steps that are identified. We need to clarify the intent of the meeting and define our next steps with timelines and responsibilities.

Other attachments: Map of IHAWP, HAWK-I and Traditional Medicaid by county and Priority Use Cases for IHIN by Priority Tier

CLOSING AND NEXT STEPS

Data Steering Workgroup will review its charter to define its role and the role of the IHIN so that all of the workgroup members and the IHIN Board agrees to the roles. This will assist in executing and delineating the roles of both of these groups *(see attached draft).*

IHIN will:

1. The IHIIN is to continue to review and implement the Tier 1 Use Cases; including the development of business plans needed for each and present them to the IHIN Board.
2. The IHIN Board is to develop a sub-committee within its Board Structure whose role is to further develop Tier 2 and 3 Use Cases. Its work will be brought back to the IHIN Board to discuss and develop strategies for the further development of those tiers.
3. IHIN Board will reach out to Iowa Healthcare Collaborative regarding the C3 community based organizations to understand what data is being collected and the software that is being used to collect this information.

Members of the Data Steering Workgroup need to send comments and/or edits of the attached charter back for Mikki's review by mid-January, prior to the Roundtable meeting in late January 2020.

Department of
HUMAN SERVICES

ROUNDTABLE DATA STEERING AND USE WORKGROUP
DRAFT CHARTER

ROADMAP

The Data Sharing and Use Workgroup is charged with creating a three (3) year Roadmap that:

- Defines the attributes of successful use and sharing of data, including:
  - Types of data
  - Resource needs,
  - Information exchange needs
- Outlines the barriers to success for use and sharing of data. Recommends strategies for overcoming those barriers regarding capabilities, alignment and standards needed to promote data exchange across the following domains:
  - Interoperability at Point of Service
  - Identification of high needs/high utilizers
  - Access to claims data for measuring and monitoring total cost of care
  - Acknowledges and plans for emerging technology
  - Includes measures and milestones of success

ROLE CLARIFICATION

Proposed role clarification between the Data Steering and Use Committee and the IHIN:

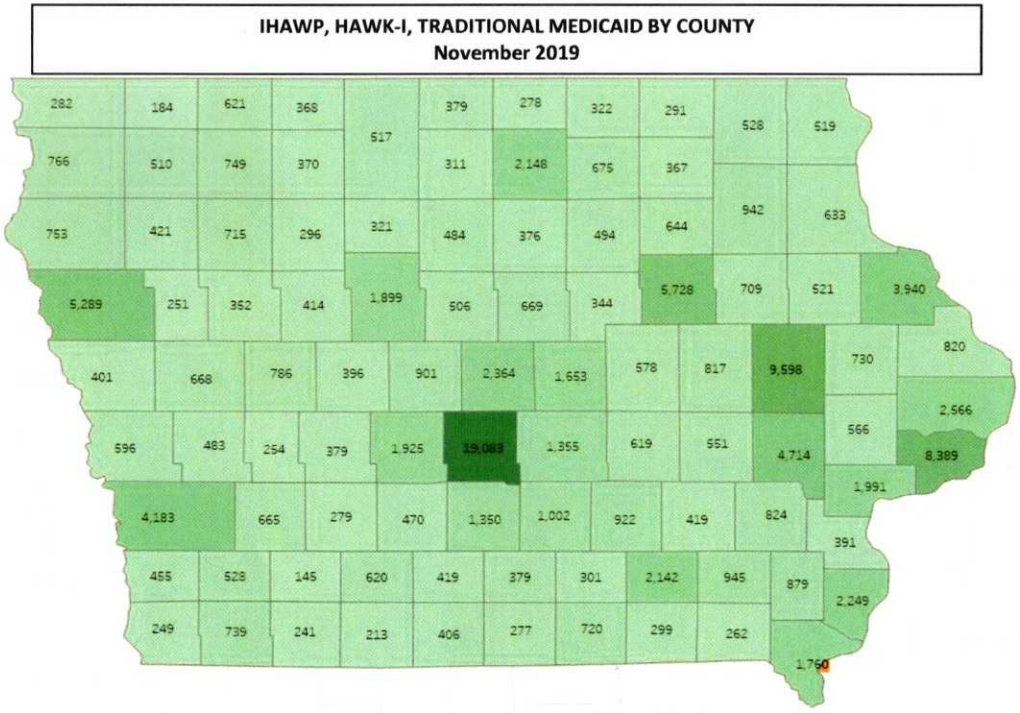
The IHIN will continue to implement the Health Information Exchange Governance recommendation from the June 20, 2019 Roundtable meeting and report back to the Data Steering and Use Committee on progress.

The Data Steering Committee will continue to perform the broader functions as outlined in the above charter.

	Use Case	Summary	Clinical Value	Business Value	Data Required
Tier 1	**Results reporting and document delivery to ambulatory providers.**	An HIO can provide a central "hub" for receiving, translating, and forwarding diagnostic results and clinical documents between hospitals and outpatient providers. In this model, each hospital and outpatient provider need only maintain a single interface to the hub, which translates the data formats appropriately to accommodate all senders and recipients. This approach replaces the highly inefficient and costly process of having each hospital and outpatient organization within a given health care ecosystem maintain numerous electronic data interfaces and perform many	· Recovers time other- wise spent by clinical and administrative staff translating, faxing, and receiving diagnostic results and clinical documents. · Moves test results and clinical documents that otherwise exist in fragmented faxes into · the EHR, allowing them to more easily inform clinical decisionmaking.	· Saves time and money spent on the staff and technologies required to maintain numerous electronic data interfaces to different trading partners.	· Test results and clinical documents from hospitals sent via HL7 interfaces to outpatient providers, who receive and integrate the data into their EHRs
	Public Health data reporting	For provider organizations that are already submitting lab results and immunization data via some means of data exchange. Analyze, appropriately format, and transmit these data to the public health department on behalf of the provider organizations.	· Ensures more complete records of patients' immunizations and reportable diseases, facilitating and improving their future care.	· Saves time and money spent monitoring test results for those that require reporting to public agencies. · Saves time and money spent building and maintaining the separate interfaces required to complete electronic submissions, or spent manually	· Diagnosis, immunization, and other clinical data required by health agencies and submitted by hospitals and outpatient providers.
	Real-time event notification.	"Publish/subscribe" infrastructures, in which certain clinical events are always reported to the HIO, which then forwards information about the events to parties that have expressed interest in being notified of them. This mechanism can be configured on an event-specific and patient-specific basis. For example, the care-management team at a health insurer could be notified each time a high-risk patient is seen in an ED, or a primary care physician could be notified upon the discharge of one of her patients from the hospital.	· Enables proactive intervention, timely outpatient follow-up after ED visits and hospital discharges, and tracking of patients' attendance at important specialist visits	· Enables stakeholders to divert patients to more cost-effective sites of care and to prevent costly avoidable hospital admissions by intervening proactively and arranging alternative care arrangements.	· Relevant health care events warranting notification may include ED visits, hospital admissions, hospital discharges, and appointments for specialist visits. · Hospitals provide the data for ED visits, hospital admissions, and hospital discharges, typically via HL7 ADT ("admit/discharge/ transfer") messages. The referring and/or consulting physician provide(s) the data for scheduled specialist visits.
Teir 2	**Summary of Care Information**	Provide access to a patient's summary of care information from a hospital visit, outpatient encounter, or specialist visit including diagnosis, treatment plan, medications, and other pertinent health information	· Informs care team about care provided, medications administered, and other information critical to clinical decisions. · Increases clinicians' chances of making well-informed and evidence-based care decisions.	>Enables care team to see a summary of treatment provided or services received increasing communication and reducing redundant testing and utilization.	> Discharge summary information, medications, diagnosis, treatment plan, etc.
	Connecting C3 Organizations	Coordinating with nonmedical providers to address patients' social needs and delivering longitudinal patient records, event notifications, and data aggregation can facilitate "whole person care" by including data on behavioral health care, substance-use treatment, and use of social services. Add additional value by providing built-in tools for care coordination, referral manage-ment, and patient tracking.	>Enables care managers to better facilitate care coordination and follow up on necessary refer- rals for both social and medical needs. >Enables providers to more effectively screen for and address the social factors that can harm a person's health.	> Better targets resources, both medical and social, to avoid more costly and avoidable outcomes, such as hospitalization. > Better tracks and measures the cost effec- tiveness of social service referrals with respect to medical utilization.	>Data on behavioral health care, substance use disorder treat- ment, and use of social services — contrib- uted by hospitals, outpatient clinics (including community health clinics), county mental health facilities, substance use disor- der treatment centers, homeless shelters, food- assistance agencies, employment agencies, and corrections facilities
	Data aggregation for population-health and utilization-management analytics	Receive, integrate, and normalize claims and/or clinical data pertaining to individual patients in a physical data repository. These data can then be made available for analysis to interested stakeholders, either by exporting the consolidated records for all applicable patients to the stakeholders, or by providing analytical software to process the data directly on the data repository.	· Enables proactive identification of patients at risk for certain poor outcomes and the proper allocation of care management resources needed to avoid those outcomes. · Enables the proactive identification and correction of patient care not aligned with evidence-based practices.	·	·
	Electronic PreAuthorization	Electronic Prior Authorization (ePA) is the electronic transmission of information between the prescriber, and payer to determine whether or not the PA is granted. NCPDP has developed technical standards to support this electronic transmission and improve the timeliness of the exchange of information.[2]		>Relieves administrativce burdens through elecronic request reducing paper forms, redundant communication >Improves time to treatment	>specific questions and data elements on a preauthorization form, clinical data to support the authorization details.
	Longitudinal patient record	Provide access to patients' health information originating from numerous sites of care either by aggregating data from across sites into a single physical patient record or by enabling retrieval of data on demand from such sites, effectively creating a single virtual patient record [1]	· Reduces potential for errors caused by poor information about allergies, prior treatments, and other information critical to clinical decisions. · Increases clinicians' chances of making well-informed and evidence-based care	· Enables provider entities that bear financial risk to avoid poor clinical outcomes and wasteful utilization, such as redundant testing.	· Medication allergies; results of past laboratory, imaging, and other diagnostic procedures; previously diagnosed and treated disorders; currently or previously taken medications; and sites and frequencies of previous medical encounters Does this include BH? Other non-medical services?

Tier 3	**Dashboards**	Present the data, integrated data, metrics in a illustrativeway to inform poitn of care, operations, and panel management, as well as progress on targets and quality improvement			
	Cost Price Transparency Data Needs and Tools to support				
	Identifying High Costs/ High Need Populations	Identify high-cost/high-need populations for IME, MCOs, other organizations to inform programs to address HC/HN			

Sum of Count	Column Labels			
Row Labels	Hawki	IHAWP	Traditional	Grand Total
$0-$500 0-18	625		1360	1985
$0-$500 19-64		12289	19351	31640
$0-$500 65 and over			1095	1095
$1000 and over 0-18	226		622	848
$1000 and over 19-64		42921	16169	59090
$1000 and over 65 and over			135	135
$501-$1000 0-18	344		1063	1407
$501-$1000 19-64		20059	8519	28578
$501-$1000 65 and over			333	333
Grand Total	**1195**	**75269**	**48647**	**125111**



Recommendation #5: Priority Use Cases for IHIN by Priority Tier

Tier 1

- Public Health Data Reporting
- Real-time Event Notification
- Results Reporting and Document Delivery to Ambulatory Providers

Tier 2

- Summary of Care Information
- **Facilitating Closed-Loop Referrals for Community-Based Services**
- Data Aggregation for Population Health and Utilization Management Analytics
- Electronic Pre-Authorization

Tier 3

- Dashboards
- Identifying High-Cost/High-Need Populations
- Longitudinal Patient Record
- Cost Price Transparency Data Needs and Tools to Support
- Decision Support Tools